VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 28, 2016

Ms. Betsy Hutchinson, Manager
Second Spring South
118 Clark Road
Williamstown, VT 05679-9449

Dear Ms. Hutchinson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 4, 2016.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

OCT 27 2016

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0386	A. BUILDING: _____ B. WING _____	C 10/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND SPRING SOUTH	118 CLARK ROAD WILLIAMSTOWN, VT 05679

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site survey was completed on 10/4/16 to review 2 facility mandated self-reports. The following regulatory violations were related to one self-report..	R100	Please see the attached plan of Correction.	10/26/16
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN (Registered Nurse) failed to assure that the care plan/treatment plan for 1 applicable resident in the sample addressed each of the resident's identified needs. (Resident #2). Findings include: Per review, Resident #2 was admitted to the facility with a history of being hypersexualized and having acting out behaviors. Progress notes reviewed since admission on 8/15/16 described the resident's exhibition of sexualized behaviors in public areas of the home. Progress notes also documented the resident's non-compliance with staff directives to him/her regarding cigarette smoking and the resident's lighting of matches inside the home, a potential safety hazard. Neither of these 2 documented behaviors were addressed on the care plan/treatment plan, per	R145		

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Betsy Hutchins	Program Manager	10/24/16

R145 - R200 POCs accepted 10/27/16 MBolton RN/PMM

Division of Licensing and Protection

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R145	Continued From page 1 review on 10/4/16. The lack of plans to address these needs was confirmed during interview with the Registered Nurse (RN).	R145	Please attached plan of Correction and Tobacco and fire Source management protocol.	10/26/16
R200 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview, the home failed to develop a policy/procedure to address resident requirements regarding the use and storage of smoking materials. This finding is related to 1 of 2 applicable residents in the sample. (Resident #2). Findings include: Per review of the medical record for Resident #2, the resident displayed unsafe actions including the lighting of matches in the home and smoking in areas not allowed on multiple occasions. The Manager stated that the facility allows residents to have in their possession smoking materials, including lighter, matches and cigarettes and there was no written policy/procedure to address the specific requirements for safe storage of these materials and no written information given to residents upon admission to inform them of the house rules regarding safe storage and possession of smoking materials.	R200		

Collaborative Solutions Corporation

Second Spring South Plan of Correction

Complaint Investigation

10 – 04 – 16

Deficiency and Corrective Action	How Monitored	Person Responsible	Completion Date
1. 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resisdent assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN (Registered Nurse) failed to assure that the care plan/treatment plan for 1 applicable resident in the sample addressed each of the resident's identified needs. (Resident #2). Findings include: Per review, Resident #2 was admitted to the facility with a history of being hypersexualized and having acting out behaviors. Progress notes reviewed since admission on 8/15/16 described the resident's exhibition of sexualized behaviors in public areas of the home. Progress notes also documented the resident's non-compliance with staff directives to him/her regarding cigarette smoking and the resident's lighting of matches inside the home, a potential safety hazard. Neither of these 2 documented behaviors were addressed on the care plan/treatment plan, per	Care Plans will be reviewed and evaluated by nursing monthly during nursing meeting to see if goals are being worked on, met, unmet or need to be changed unless an unusual or significant change in behavior is observed which will prompt an immediate review. Any changes to the Nursing Care Plans will be made within 48 hours of the decision by a nurse assigned to the task and will be reviewed by the Nurse Manager.	Nurses/Nurse Manager	10/26/16

review on 10/4/16. The lack of plans to address these needs was confirmed during interview with the Registered Nurse (RN).

4.0 Nursing Care Plans

4.1 Nursing Care Plans General

Nursing Care Plans are located on the Nursing Server (Addendum 4.A) and must be completed within 24 hours of a new resident coming to SS. The Care Plans at SS, specifically the interventions applied, are meant to compliment the Treatment Plans that the resident and Case Managers complete shortly after admission. Care Plans will be reviewed and evaluated by nursing monthly during nursing meeting to see if goals are being worked on, met, unmet or need to be changed unless an unusual or significant change in behavior is observed which will prompt an immediate review. They will also be reviewed to insure that they continue to compliment the treatment plan. Changes will be made within the nursing meeting through discussion and analysis of all nurses present at the meeting and will be documented. Unusual or significant changes in behavior will be documented in the care plan documenting care and services needed to address documented behavior. Any changes to the Nursing Care Plans will be made within 48 hours of the decision by a nurse assigned to the task and will be reviewed by the Nurse Manager.

2.	5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview, the home failed to develop a policy/procedure to address resident requirements regarding the use and storage of smoking materials. This finding is related to 1 of 2 applicable residents in the sample. (Resident #2). Findings include: Per review of the medical record for Resident #2, the resident displayed unsafe actions including the lighting of matches in the home and smoking in areas not allowed on multiple occasions. The Manager stated that the facility allows residents to have in their possession smoking materials, including lighter, matches and cigarettes and there was no written policy/procedure to address the specific requirements for safe storage of these materials and no written information given to residents upon admission to inform them of the house rules regarding safe storage and possession of smoking materials. Please see the attached Tobacco and fire source management Protocol.	Program Manager and Compliance Officer will ensure that Tobacco and fire source management Protocol is reviewed with all staff and placed in protocol binder for all staff to review as needed.	Team Leader/Recovery Counselor/Case Managers The Tobacco and fire source management Protocol will be reviewed with residents during Resident Meeting and upon admission where it will be added to the Resident Guideline Handbook that is given to every resident.	10/26/16
3.				

Collaborative Solutions Corporation

SUBJECT – Emergency Response Protocol – Tobacco and fire source management

Introduction and Purpose

To provide a clear outline of how to respond to unsafe smoking inside or outside of the facility

Summary

While Collaborative Solutions Corporation believes that in most cases residents can manage their own tobacco consumption and matches/lighters there are occasionally times were we will need to initiate a safety protocol to keep the resident and facility safe. In the event that a resident is found to be smoking, or has smoked, in the facility or is found to be lighting matches or a lighter in the facility or it has been determined that the resident has acted in an unsafe manner outside of the facility with their smoking material, the following steps are to be followed.

Response

- Initiate the Emergency Calling Protocol
- Explain to the resident that it is unsafe to smoke or light matches / lighters inside the facility (or what unsafe behavior prompted this response) and that we have a designated smoking area for that purpose.
- Ask for all matches, lighters and smoking tobacco products.
- Should the resident refuse to turn these over, the resident shall be placed on a 1:1 Self Injurious Behavior level until such time as the requested items are surrendered. This is to insure that the resident does not present any fire safety hazards.
- A room check will be immediately initiated in accordance with the Room Check Protocol to determine if other smoking tobacco products or matches / lighters are in the residents room.
- All items removed will be stored in the central office in the resident's black folder, inventoried (to include number of smoking tobacco items) and secured.
- Proper documentation will be made in the EHR, on an incident report form and a notation restricting possession of smoking tobacco and matches / lighters will be made on the Behavioral Safety Order Form (green sheet).
- When the resident requests a smoking tobacco item, the item will be provided to the resident and the appropriate reduction in number made on the inventory sheet.
- Staff will accompany the resident to the smoking area and will light the smoking tobacco item for the resident.

Return of Items

When the resident is assessed by the clinical team and nursing as able to contract for safety and currently able to safely maintain possession of their smoking items, these items will be returned to the resident and appropriate documentation completed (EHR, change to the Behavioral Safety Order Form etc).